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ABSTRACT

This paper describes the involvement of faith in healthy community efforts, highlighting Nebraska's plan to strengthen and transform public health at the state and local level. This involved expanding health promotion and disease prevention programs into nontraditional settings (schools, worksites, and churches). A faith team was organized to identify how faith communities could improve public health. Though the team has worked together 2 years, parish nursing and health ministry efforts have occurred in Nebraska for 12 years. A Health Ministry has been established, with the idea of creating a community-based outreach program to facilitate collaboration and commitment of health professionals and health-related organizations. The COME ALIVE Health Ministry of one Nebraska church was established to improve congregation members' quality of life and health through body, mind, and spirit. As part of the church family, volunteer health professionals provide a caring outreach of health education instruction, listening to members' needs, coordinating referrals, and facilitating the integration of faith and healthful living. This paper describes the creation of COME ALIVE, highlighting: team organization; gaining support; assessment and reassessment; program elements; selecting a name; drafting a mission statement; writing goals; selecting programs; establishing a timeline; implementation; and evaluation. (Contains 20 references.) (SM)

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Learning How To Develop A Local Health Ministry Program

&

Linking With State And National Agendas

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LEARNING HOW TO DEVELOP A LOCAL HEALTH MINISTRY PROGRAM & LINKING WITH STATE AND NATIONAL AGENDAS

There is a faith and health movement spreading across the nation. It can be seen in the growth of congregation-based nurse programs, health ministries, and interfaith service organizations engaging in health-related activities. Through these faith-based structures, faith groups and communities are receiving the benefits of health education, counseling, and many other types of support. This work grows out of the health tenets that exist within every faith tradition (US Department of Health and Human Services, 1999).

Background

America is experiencing a health crisis. In the United States and Nebraska, chronic diseases such as heart disease, cancer, and stroke, are the leading causes of death. These diseases accounted for 9,165 deaths in Nebraska in 1998 or sixty percent of the total deaths (Nebraska Health and Human Services System, 1999). Genetics and access to health care play a role in disease outcomes, but individual behaviors and environmental factors are responsible for nearly 70% of all premature deaths in the United States. Approximately, 33% of the poor have no health coverage, thus denying access to care for 44 million persons, one-third of whom are children (U.S. Bureau of Census, 1999). This crisis forces us to recognize that people have shifted responsibility from themselves to the medical care system for their health care.

Advantages of Health Ministry/Parish Nursing Programs

Communities that are successful in addressing these health concerns and their multiple risk factors (i.e., behaviors) utilize multiple strategies within various settings that people live, work, play, and worship. Faith communities/congregations offer many strengths to the health promotion and disease prevention practitioner in the design of programs, including: (1) faith communities offer a place for people from diverse ethnic and socioeconomic backgrounds to gather; (2) faith communities maintain contact with individuals and families throughout the life cycle from birth to death; (3) faith communities are perceived as a "safe place"; (4) faith communities are enduring institutions that have been involved in health care for centuries; (5) faith communities carry out their mission through volunteer and outreach activities; and (6) faith communities historically reach out to people in need; (7) faith communities are considered private organizations; therefore, they are able to offer health services and programs with spiritual components. Pastors are particularly noted for their efforts in the areas of primary and secondary prevention (Quinn & Talley, 1974; Bentz & Bruder, 1970) as well as serving as catalysts for health-related behavioral and social change (Levin, 1986).

The Role of Faith & Health in Communities

Delivering health services and health promotion and disease prevention programs to congregations offers a particularly captivated audience in terms of numbers. There are 10,000 congregations with greater than 2,000 members each (Adventist Health, 1997). The opportunity that these numbers present is encouraging in light of the fact that health

care practitioners are often isolated from an awareness of community needs. The churches within a community have more contact with these people and are able to assess and meet those needs in a way the hospital organization can not. Churches provide a means to serving individuals who may or may not access health care in a traditional way.

As noted in the national Healthy People 2010 Objectives, "Places of worship may be a particularly important setting for health promotion initiatives, and they may effectively reach some under served populations. In addition, these groups and organizations can also be strong advocates for educational, policy, and environmental changes throughout the community (U.S. Department of Health and Human Services, 2000)."

Scientific Evidence to Support Faith and Health Outcomes

So, how strong is the empirical evidence linking religious involvement and health outcomes? In the late 1980s, a series of review articles summarized evidence concerning religious effects on morbidity and mortality (Jarvis & Northcott, 1987; Levin & Schiller, 1987; Levin & Vanderpool, 1987; Levin & Vanderpool, 1989; Troyer, 1988; Levin, Chatters, Ellison, & Taylor, 1996). C. G. Ellison and J. S. Levin summarize the findings in the following paragraph (1998):

> These reviews drew on several hundred studies containing one or more religious indicators and one or more physical health outcomes, some dating back to the 1800s. Taken together, they present convincing evidence that rates of morbidity and mortality vary across religious and religious denominations, as well as less, but still somewhat consistent, evidence that, on average, high levels of religious involvement are moderately associated with better health status. These findings have appeared in samples of men and women, in samples drawn from numerous

> racial and ethnic groups, in samples of persons from a wide range of religions (Christian and non-Christian groups, in Western and non-Western settings), and among individuals at various stages of the life cycle and persons from diverse social class backgrounds. In the language of epidemiologists, it appears that religion, in a broad sense, represents a protective factor that offers a small but significant primary-preventive effect against morbidity in populations (p. 701).

Representative programs and activities that facilitate improved health outcomes include church-based health centers, church-based health promotion/disease prevention interventions involving diabetes, hypertension, and maternal and child health (i.e., screenings for various risk factors), community mental health counseling and training programs, and health policy initiatives (Chatters, Levin, & Ellison, 1998). Diseases examined in this body of research are heart disease, hypertension and other circulatory ailments, stroke, cancer (various sites), and gastrointestinal disease, as well as over all self-rated health, physical disability, and self-reported symptomatology. Most of the studies showed statistically significant salutary effects of religious involvement on health (Levin & Schiller, 1987).

National Level Faith & Health Efforts

Health programs within a wide array of faith-based settings are gaining broad-based support from representatives of religious institutions and public professionals at local, state, and federal levels. Partnership development is an ongoing activity for the Centers for Disease Control (CDC), particularly since 1999 when a forum entitled "Engaging Faith Communities as Partners in Improving Community Health" and co-sponsored by CDC, The Carter Center, and the U.S. Department of Health & Human Services was held to address three topic areas.

The first issue involved ***separation of Church and State***, an important consideration for effective collaboration between public health and faith. A three-part test developed by the Supreme Court to examine the constitutionality of government efforts. First, the program has to have a valid secular purpose. Second, the primary effect of the program should neither advance nor inhibit religion; the main effect of any program should be the betterment of public health, either by education, intervention, or other mechanisms. Finally, the program should not foster excessive government entanglement with religion.

The second area of interest was ***understanding what science has discovered regarding the influence of faith and health*** at the individual and community levels. Rev. Gary Gunderson described the alignment of religion and health assets as a faith and health movement that can change communities and is currently growing in the nation. Since 1991, the National Institute for Healthcare Research has been conducting and mobilizing scientific research on the relationships between spirituality and physical, mental and social health. The research findings indicated that about 80% of patients would like to have their spiritual needs addressed in their care, but these needs are considered far less than 20% of the time among these patients. (King & Bushwick, 1994). Most patients believe that prayer helps in terms of healing, and in fact, the strong connection between faith and well-being has led more than 30 medical schools in the United States to offer courses on spirituality and medicine.

The third area of focus was to articulate a ***description of current partnerships and best practices*** of faith and health collaborations involving CDC or other federal

agencies. Some of the earliest partnerships between faith groups and health organizations stemmed from the need to combat HIV prevention through social networks that reach out to several different populations including racial/ethnic minorities. Later, other initiatives such as the Witness Project, a community-based, breast and cervical cancer education program, and Project Vision, a health promotion program designed to provide educational classes that teach students how to modify their diets to be heart healthy, exercise classes with babysitting for the children of participants, blood pressure and cholesterol screenings, and health education sessions were conceived. These types of partnerships continue to invent creative ways to improve community members' health.

State Level Faith & Health Efforts

Healthy community efforts within faith communities are also discussed in Turning Point, Nebraska's Plan to Strengthen and Transform Public Health in Our State. The Plan was developed in response to Turning Point, a grant awarded to Nebraska Health and Human Services System by the Robert Wood Johnson Foundation for the purpose of developing a strategic plan for strengthening and transforming public health at the state and local level. One of the major strategies in the Nebraska Plan was to expand health promotion and disease prevention programs in more non-traditional settings (e.g., schools, worksites, churches, and senior centers). In response to this strategy, a faith team was organized to identify how the faith communities could improve public health. The team has been working together for just two years, but parish nursing and health ministry efforts have been taking place in Nebraska for at least 12 years. The team is comprised of members from Scottsbluff, Grand Island, Columbus, Lincoln, and Omaha.

Nebraska who have an interest in community health, health ministry, and/or parish nursing.

The Faith Community Team has partnered with several organizations and key stakeholders to formulate a statewide network aimed at strengthening health promotion, providing greater outreach to those entities with health disparities, and linking health communities with faith communities across the state. The first major activity of the team will take place in September, 2000, when the Faith Community Team and Saint Francis Medical Center will host the inaugural Health Ministry Conference in Nebraska.

Subsequent work of the Subcommittee will be aimed at creating a Nebraska Health Ministry Network. The Network will strengthen efforts in faith communities across the state, in both rural and urban areas, to address multiple risk factors and social/environmental interactions that relate to chronic disease in the state. Creating links with local health departments, healthy community efforts, and community action agencies across the state will also facilitate continued methods to improve immunization rates, access to health information and referrals, and connect seniors to needed resources. As a whole, the focus and purpose of the Nebraska Health Ministry Network will be to create a community-based outreach program, which will facilitate the collaboration and commitment of health professionals and health-related organizations. Thus, the structure and resources of the faith community will assist in meeting the diverse health and wellness needs of the people of Nebraska.

Fitting the COME ALIVE Health Ministry into the Big Picture

The goal of the COME ALIVE Health Ministry is to improve the quality of life and health through body, mind, and spirit among congregation members. As part of the church family, volunteer health professionals provide a caring outreach of health education instruction, listening to members' needs, coordinating referrals to community resources, and facilitating the integration of faith and healthful living.

The COME ALIVE Health Ministry of the College View Seventh-day Adventist Church is one of approximately 25 like programs in the State of Nebraska, which serve a specific congregation and surrounding community members through an organized approach to keeping people well. In an effort to promote multi-level cooperation and infrastructure, national and state level organizations and agencies are working to build sufficient capacity to support local health ministry programs like COME ALIVE in the near future through grant dollars, technical support, and materials/resources.

Hurdles Jumped During the Creation of COME ALIVE: A Case Study

Hurdle #1 – Organizing a Team

The COME ALIVE Health Ministry team, which arose from a needs assessment process of congregation needs and the early desire by a few nurses in the congregation to help improve quality of life for members. A volunteer registered nurse and health educator serve in semi-pastoral roles. In addition to these co-leaders, additional team members were recruited through personal invitations and church bulletin announcements to develop a mission statement, goals and objectives for the ministry; implement a marketing plan to introduce the ministry to the congregation; conduct a health needs

assessment of the congregation; plan and implement appropriate programs and activities to meet identified needs; and evaluate effectiveness of programs.

The 20-member volunteer team is comprised of individuals from diverse educational backgrounds that relate to health, including Physician Assistants, a College Health Administrator, a Health Educator, Registered Nurses, a Respite Worker, students, Family Life Pastors, a Construction Manager, Health Club owners, a Soup Kitchen Cook, and a Home Health Provider. Additional members of the congregation who are health professionals or interested in health participate in some fashion while specific programs are offered throughout the year.

COME ALIVE is facilitated by the establishment of specific roles within the group and methods of accomplishing work. First, monthly meetings were scheduled at the church in a casual atmosphere and then later, designated recorders were selected to document minutes of the meetings and distribute relative information. Subcommittees were also formed to tackle smaller projects like creating a ministry logo and articulating mission/vision statements.

Hurdle #2 – Gaining Support

The College View Seventh-day Adventist Church has approximately 2,000 members, is linked to Union College, and is supported by a 10-member pastoral staff. Lincoln, Nebraska, a city with a population of about 220,000, is home to six Seventh-day Adventist Churches that have rich tradition of promoting healthy lifestyles. The private K-12 Seventh-day Adventist School System in Lincoln provides regular instruction on the importance of healthy eating through a vegetarian diet, prayer and Bible study,

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physical activity, and tobacco and alcohol cessation. Together, the Lincoln community, the six Seventh-day Adventist Churches, Union College, and the school system form a strong partnership for supporting health living and health ministry.

Building relationships constitutes one of the most important steps toward making any healthy ministry program a success. In terms of human resources, gaining support from the pastoral staff, church officials and stakeholders provides the necessary validation and reinforcement that the congregation needs to lend their support through participation in the health ministry.

To address this key component, the COME ALIVE Health Ministry co-leaders scheduled a one-hour block of time with the 10-member pastoral staff to present information about the history of parish nursing/health ministry as well as explain the strategic planning process that had been accomplished. During the presentation, a mission and vision statement, core values, and goals which mirrored that of the churches strategic plan were reviewed; an explanation of the assessment process and survey results were articulated; and programmatic plans were shared for the next two years. The presentation yielded enthusiastic support for the ministry through heightened understanding of health ministry, which, as mentioned previously, is invaluable for future success.

Union College, adjacent to the College View Church facility, offered several collaborative opportunities for future programming success by utilizing faculty and student support and expertise. The college offers several major programs for students to choose from, a few which would be particularly helpful during the development of the

COME ALIVE Health Ministry, including a Graphic Design Program, Nursing Program, Physician Assistants Program, and Health and Physical Education Program. For example, COME ALIVE envisioned providing internships for Health and Physical Education, Nursing, and Physician Assistants to assist with home visits, exercise programs, and screenings (i.e., blood pressure, cholesterol, glucose, flexibility, and body fat percentage). Faculty could provide expertise as program leaders, health lecturers, and health ministry trainers.

Financial support from the church budget, denomination and community grants, state funding sources, and fundraisers are the methods by which health ministry programs may support programs and services. The College View Church wrote a grant and received $2,500 from the Association of Seventh-day Adventist Nurses for the purpose of developing a parish nursing/health ministry program in 1997. In addition, it is anticipated that approximately $500 from the church budget will be contributed annually for program planning.

Hurdle #3 – Assessment & Reassessment

A health ministry evolves from the needs of the congregation and the response of the local church community. The assessment process should be outlined from predetermined objectives, and be the foundation of any health ministry program. It should also establish baseline data so that subsequent assessments can measure the impact of a health ministry program over time.

COME ALIVE consulted with the University of Nebraska Education and Assessment Research (NEAR) Center during the development of a suitable and

appropriate survey. The survey design and evaluation techniques were aimed at determining the demographics of the congregation, frequency of varied health conditions, and likelihood of participation in specific and varied health programs (see Appendix).

Two church services held on the same day (i.e., at approximately 9:30 a.m. and 11:20 a.m.) were chosen as the ideal time to collect data. Prior to the distribution of surveys, one of the College View Seventh-day Adventist pastors and a COME ALIVE member were chosen to introduce the concept of health ministry and explain the purpose of conducting a survey to the congregation. This brief three-minute introduction was given at the beginning of both church services. In addition, a short video on health ministry was shown to visually illustrate health ministry activities. Subsequent to the introduction given by a pastor and COME ALIVE member, an explanation on how to complete the survey was provided. Immediately following the introduction and directions, members completed the survey, which was included in their bulletin as an insert. Church deacons then picked up the surveys.

The NEAR Center analyzed data and provided survey results in the form of frequencies. Demographic information such as age, gender, marital status, educational level, and employment status had never been collected at the College View Church. Results showed a stable distribution of ages from 18 – 85 years of age, relatively high levels of education, a higher proportion of female respondents, and a majority of married and full-time employed congregation members (see Figures 1-5). Survey results were based on a 19.8% return rate.

Information was also collected on the best times and days of the week to offer programs, the interest level associated with receiving a home visit, and whether members possessed health insurance coverage. The most valuable outcome of the survey results in terms of program planning for COME ALIVE was the top ten potential programs of interest (see Figure 6). In essence, congregation members communicated that preventive health programs like exercise, nutrition, stress management and weight loss were most important to them, and they were most likely to participate in programs dealing with these topics.

A reassessment of health program interests and needs for COME ALIVE will most likely be discussed as the team progresses and develops. Ideally, health assessments should be conducted once every three years in an effort to keep offering timely programs and seek input from the congregation. A reassessment would be based on both the successful aspects of the previous survey process and recommended changes to the survey content, construction, methods of collecting data, analysis and information dissemination.

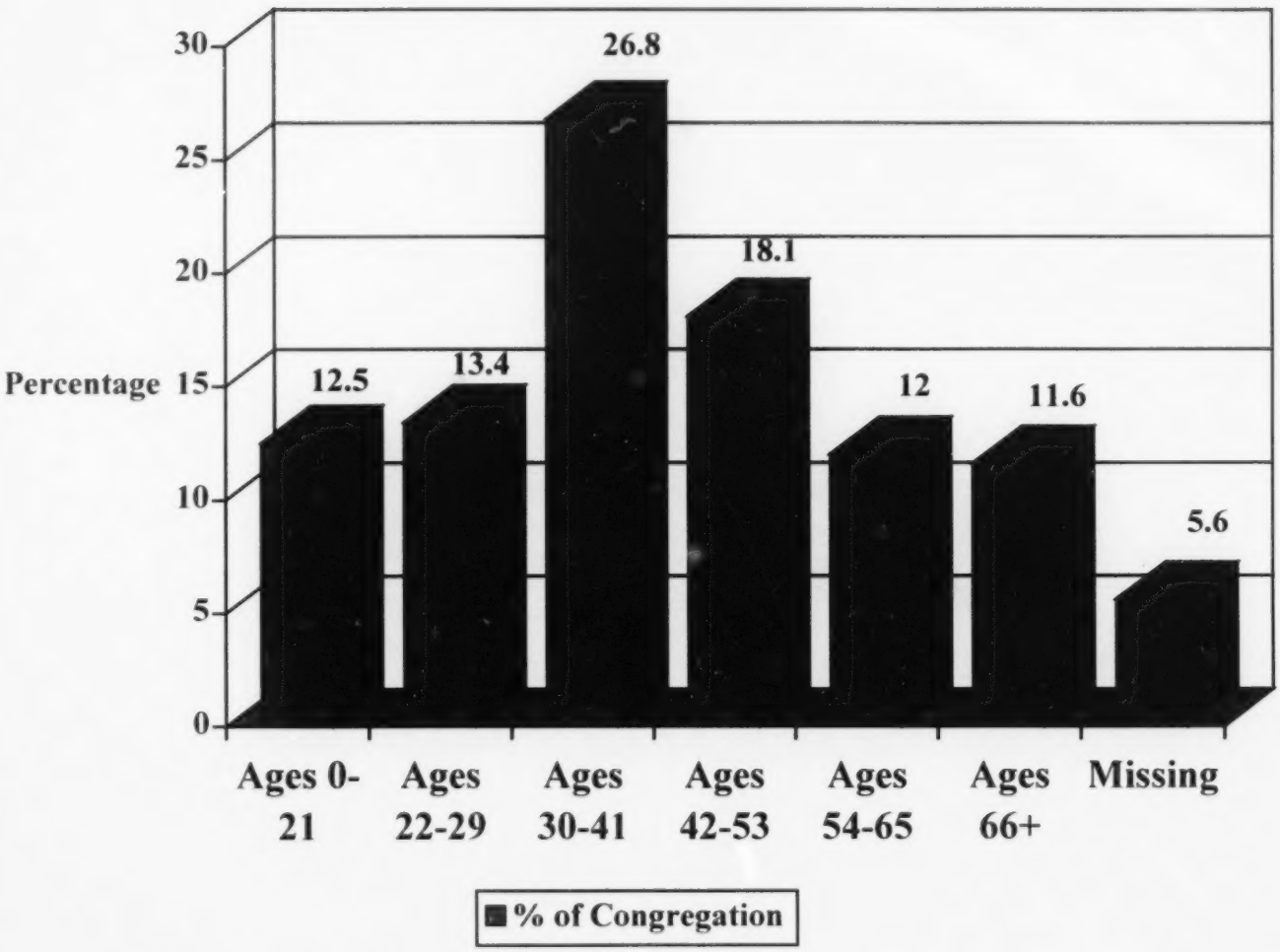

Figure 1. Age Distribution

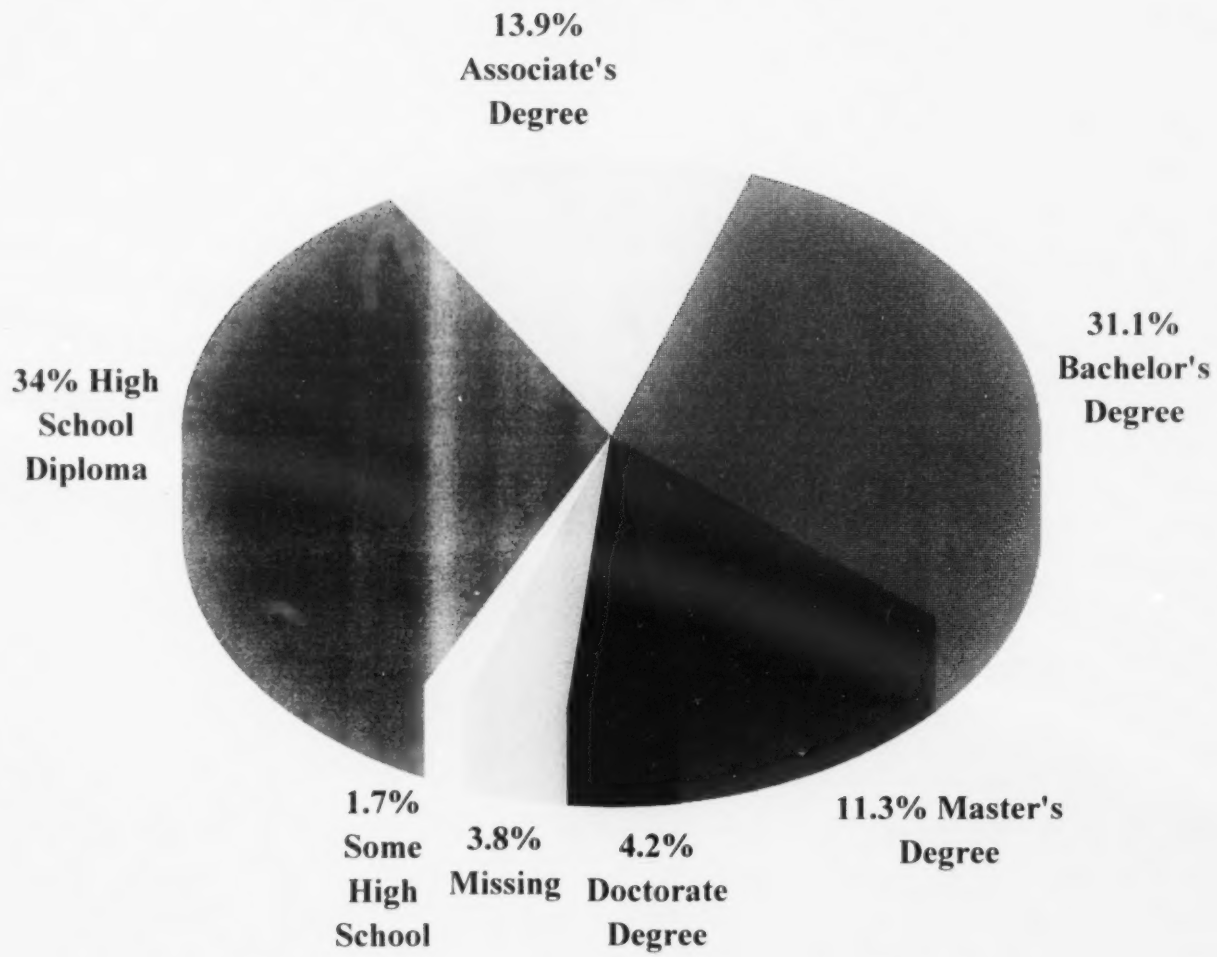

Figure 2. Level of Education

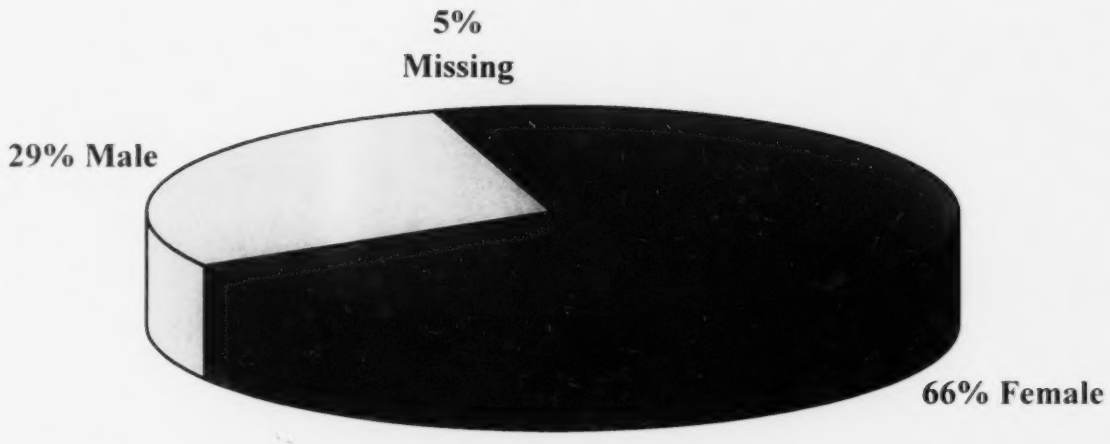

Figure 3. Gender

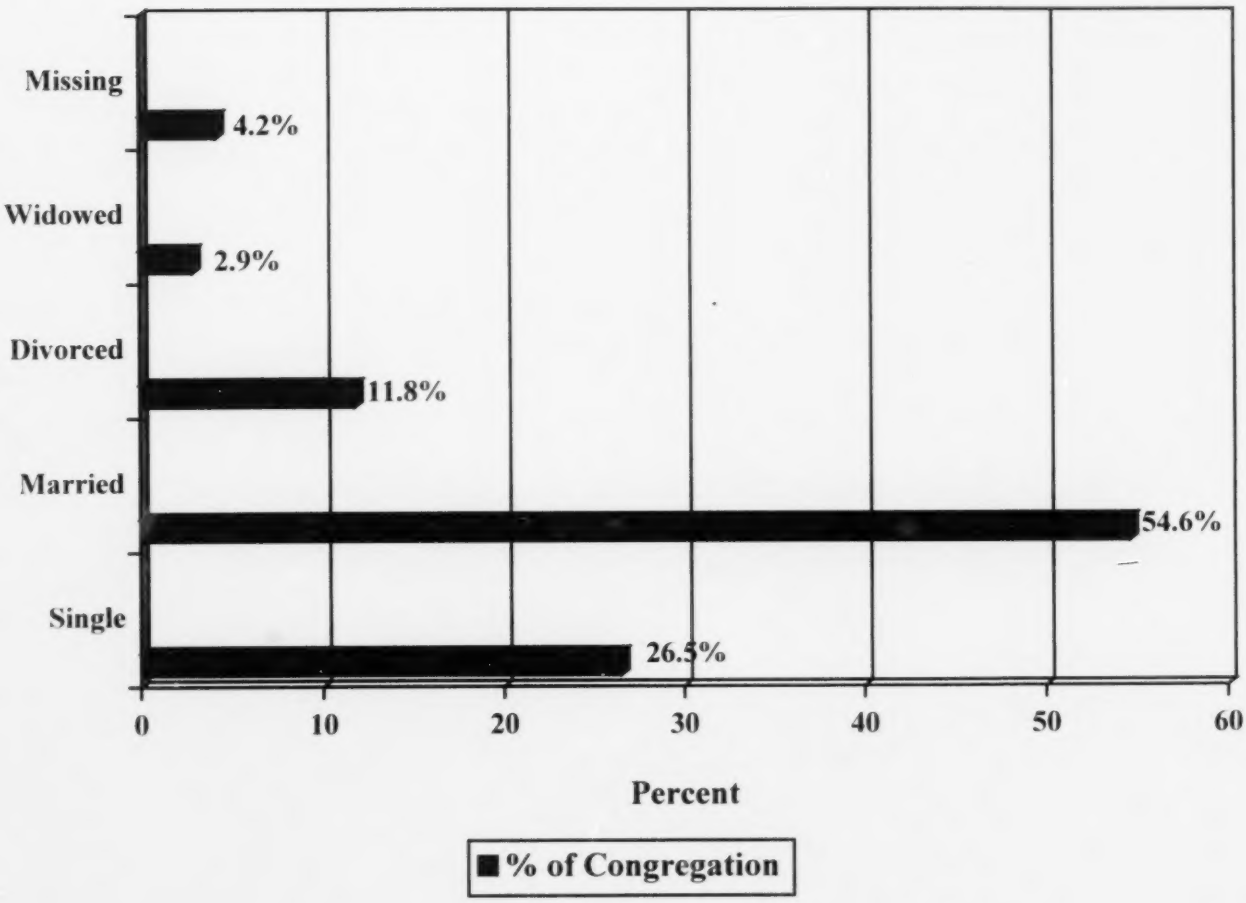

Figure 4. Marital Status

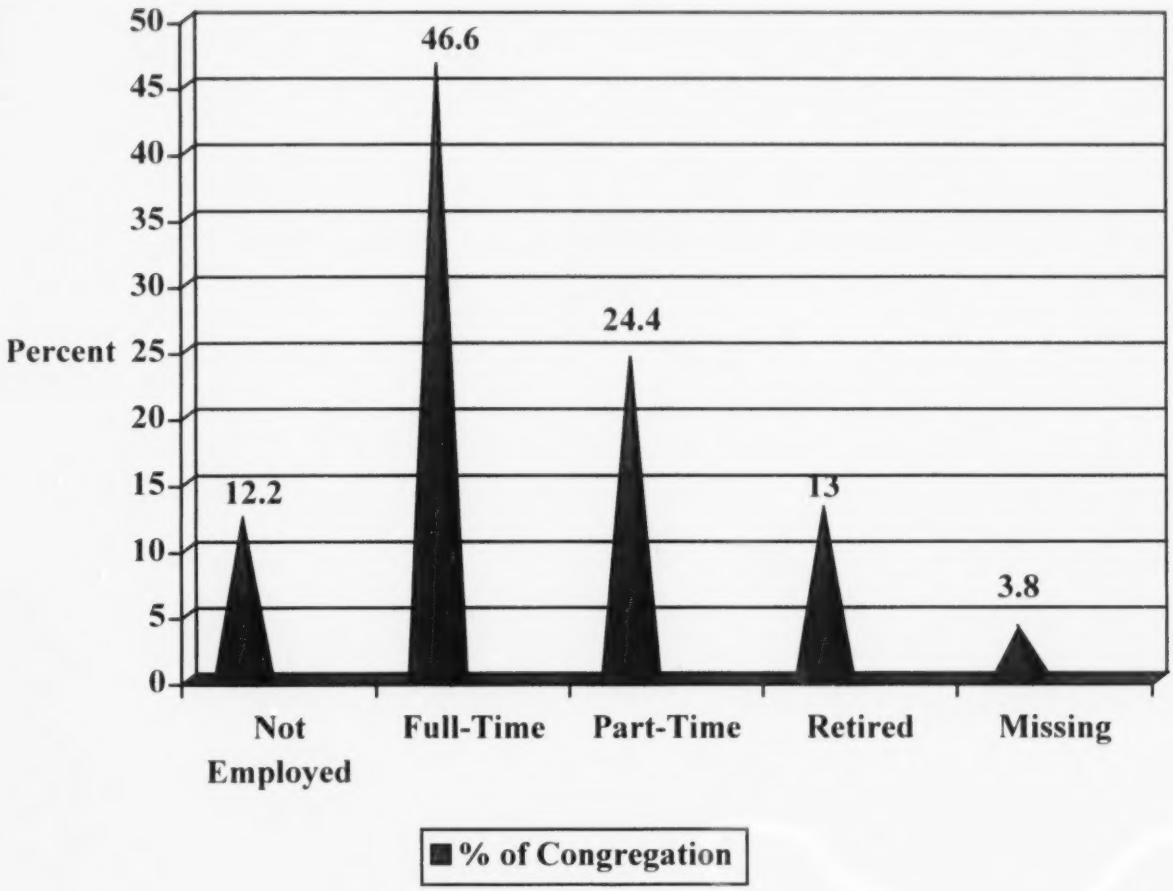

Figure 5. Employment Status

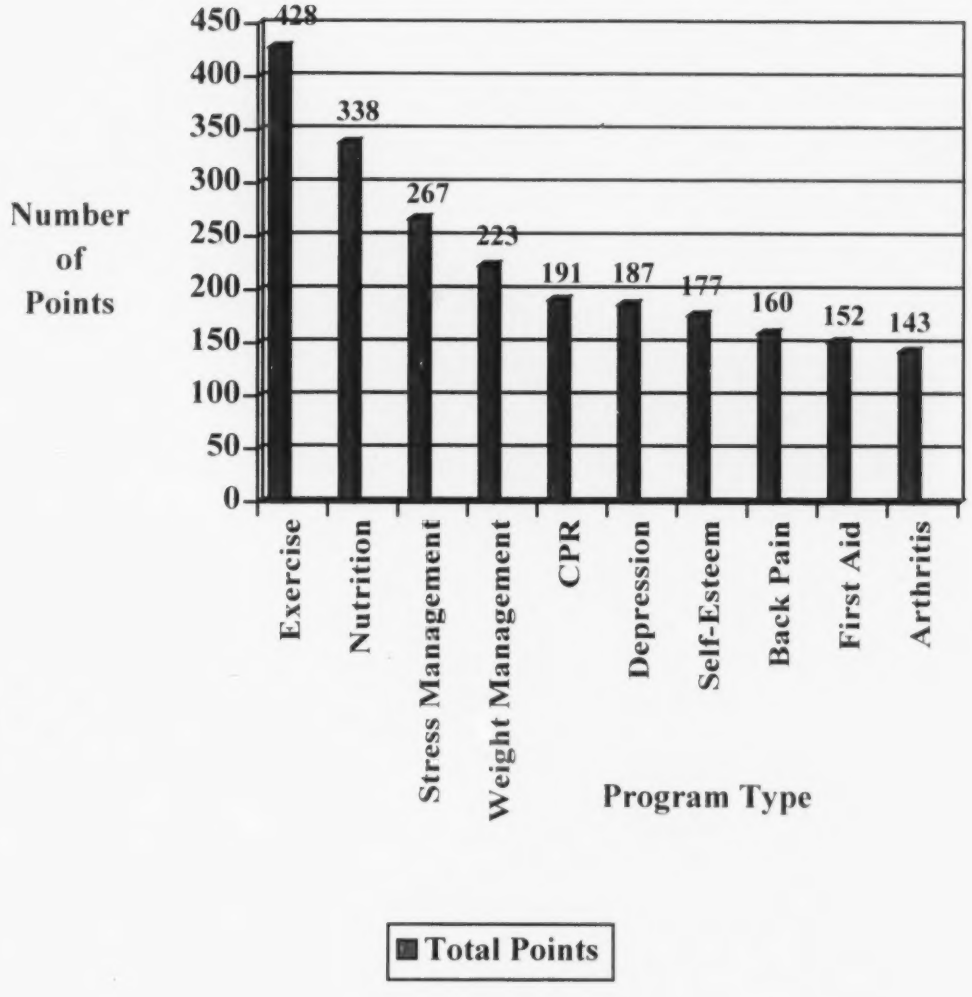

Figure 6. Top Ten Potential Programs of Interest

Hurdle #4 – Program Elements

In the case of COME ALIVE, data analysis and reporting quickly led to researching vision elements of the program. Still, a question lingered about what general categories the selected activities should be tested against for appropriateness? Throughout the strategic planning process, three main activity areas kept reoccurring and eventually yielded the final program vision elements, including Health Advocacy, Health Counseling, and Health Promotion. Future activities would fall under one of the three categories.

Health Advocacy is rooted in acting on behalf of congregation members who may or may not be able to successfully address his/her own health needs or concerns. For instance, a congregation member that lives in a nursing home may not be receiving proper care, and he/she may need an advocate to contact his/her health care providers to remedy the situation.

The ***Health Counselor*** provides information about health resources in the church and community and performs home visits to various groups of congregation members (e.g., new and expectant moms, recently released hospital patients, the elderly, and the disabled), while, the ***Health Promotion*** role revolves around providing health education and disease prevention activities (e.g., blood pressure screenings, parent education, fitness classes, and cooking demonstrations).

Hurdle #5 – Selecting a Name & Drafting a Mission Statement

A shared vision of health for the future should reflect the ideal health status and quality-of-life the community hopes to achieve as a result of improving community health (Nebraska Health and Human Services System, 1997). This vision should help the faith community determine the direction of changes, extent of the journey to improve the health of its members, and the philosophical foundation and underlying methods that are needed to improve health status within the faith community.

The Mission/Vision Subcommittee, as it was called, worked collaboratively with designated strategic planners from the College View Church to draft a mission statement, vision statement, and core values which were an extension of the overall strategic plan for the church and reflected key values of the denomination. An initial working document was presented to the COME ALIVE Health Ministry team for review, polishing, and final approval.

The approved health ministry strategic plan (see Figure 7) provided the foundation needed to create a ministry name, "COME ALIVE, A Health Ministry of College View Church, and begin preparing a logo design. Both of these creative elements necessitated skills not present in the immediate health ministry team. As a result, a Professor of Graphic Design and a Professor of Communications from Union College were invited to present methods used to craft organizational names and logos. Both experts provided best practices regarding the processes and offered suggestions on potential names and logos. After several months of deliberation and work from the two professors, a name and logo were adopted were adopted (see Figure 8).

Mission Statement

COME ALIVE is a health ministry inspired by Christ's example helping others experience health and wholeness of mind, body, and spirit.

Vision Statement

Large enough to help the community, small enough to help one person at a time. A health ministry responsive to the changing needs around us.

Core Values

- Help others reach their highest wellness potential
- Be accessible
- Model a Christ-like manner
- Be compassionate

Figure 7. COME ALIVE Strategic Plan

Figure 8. COME ALIVE Name & Logo

Hurdle #6 – Writing Goals

Key health issues are identified by examining survey data and reviewing existing and potential resources. Once completed, prioritizing key health issues using a systematic process should enable the faith community to identify the initial priority health issues (Nebraska Health and Human Services System, 1997).

Building goals around the strategic mission statement, vision statement, core values, and assessment results was the approach used by COME ALIVE. As is true in most cases, COME ALIVE goals attempted to both educate the congregation about what is the concept of health ministry and address health needs and interests of the congregation based on survey results. Eleven broad COME ALIVE goals were targeted for the years 2000 – 2001, serving as the compass for crafting specific programs to achieve these goals (see Figure 9).

Based on feedback from the COME ALIVE health ministry team, it was recommended that the Health Promotion element be the main thrust of goals and subsequent activities during the first two years of implementation and evaluation. This was due in large part because the team felt that gaining the congregation's trust would be imperative for future efforts, especially those aimed at providing home visits.

Hurdle #7 – Selecting Programs & Establishing a Timeline

Activities, or tasks, are the core of project plans. Potential health ministry activities for COME ALIVE, which fall under the three elements of Health Promotion, Health Advocacy, and Health Counseling, are diverse, numerous, and limited only to the imagination and budgetary resources. In fact, it is not possible to sponsor and offer all

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- Share survey results with the congregation.
- Promote future plans and programs of COME ALIVE with the congregation.
- Educate the congregation about the link between faith and health as well as encourage participation in COME ALIVE health programs.
- Support health ministry training/parish nursing training opportunities for team members.
- Invite volunteers to assist with program implementation.
- Provide health education information on various health topics for the congregation.
- Create a visible and accessible point of contact with a COME ALIVE team member for congregation health concerns.
- Celebrate participation in health programs and activities.
- Encourage involvement in healthy lifestyle activities like exercise.
- Construct an ongoing database of health resources.
- Evaluate programs for effectiveness and interest.

Figure 9. Eleven COME ALIVE Goals for 2000-2001

the programs that one would like to as a health minister. Volunteers have select numbers of hours available to assist with program development and implementation, and some programs may be more or less embraced, depending on the needs of the congregation.

The COME ALIVE Health Ministry chose to focus a majority of their efforts on health promotion programs during 2000-2001 in an effort to address the top ten potential programs of interest (i.e., based on survey results). Programs that supported each of the three COME ALIVE elements (i.e., Health Promotion, Health Advocacy, and Health Counseling) were identified through a brainstorming process during three different meetings. Examples of health promotion programs may include physical activity classes, a seminar on aging, stress management classes, time management workshops, CPR and First Aid training, a chemical dependency series, healthy eating and cooking instruction, mental health and depression support groups, health screenings, and a spiritual Christmas Workshop. Within Health Advocacy programs, the health minister might help maintain proper care for nursing home patients, check to see that the church facility and congregation members' homes have fire/smoke alarms that work, work toward passing a smoke-free designation for the church facility, and participate in and follow-up with individual cases and related needs identified by the pastoral staff. Health Counseling frequently covers mostly home visits (e.g., pre- and post-hospital visits, nursing home visits, expectant and new mother visits, dysfunctional family visits, and teenage mother visits), personal prayer requests, worship/devotional services in nursing homes, resource referrals for various needs (e.g., medical service for the uninsured, personal/family crisis

intervention, and special concerns that relate to disabilities), and ministry to the homeless.

Once the lists of programs were compiled within the three elements, team members voted for their top five programs overall by placing self-adhesive sticker-dots next to their choices. As a result, the top five programs were tallied and cross-checked with the COME ALIVE goals for alignment, appropriateness, and manageability with existing funding. Creating a resource referral database, developing an exercise program with incentives, contracting with local vendors to offer health screenings, providing a nurse on staff for church services, and organizing a health fair were the top five programs that the COME ALIVE team would plan and implement in the future.

Hurdle #8 – Implementation

To develop a workplan, the activities defined in the project plan should be broken down into smaller units over time. Responsibility for each of these functions is then assigned to different members of the faith team. There are many benefits to an organized work planning system. Once projects are broken down into their final levels of detail, these activities become achievable at the individual level. The efforts of all faith volunteers are coordinated under the direction of health ministry leaders. In turn, volunteers become committed to completing their assigned tasks and helping the success of the project. (Wilson & Glaros, 1994).

Based on the number of hours volunteers were available to organize and implement programs, financial resources, the degree of complexity for a particular program, advantageous times of the year to offer certain programs (e.g., offering an exercise program in January), a time line was framed to include all eleven COME ALIVE

goals either implicitly and/or explicitly from April 2000 – April 2001. The work plan, which included a time line, incorporated adequate time to market each of the programs to the congregation and coordinate programs with the peak attendance rates of the church members. For example, during summer months many of the College View Church members take vacations, and the Union College students leave Lincoln for summer break. This would not be a good time to introduce a new program.

COME ALIVE team members voted to introduce the concept of health ministry in general and the COME ALIVE Health Ministry specifically by organizing a health fair as the premier event. This event would allow congregation members an opportunity to learn about a variety of health information that was available from community groups and agencies, participate in an opening 1.5 mile group walk to promote physical activity, listen to a lecture given by a cardiologist on preventing and treating heart disease, participate in health screenings, possibly win door prizes, and socialize while learning to take responsibility for one's health. Health professionals (e.g., mental health professionals, dentists, optometrists, chiropractors, physical therapists, nurses, physical educators, exercise physiologists, and physicians) and those interested in health (e.g., writers, drama leaders, construction workers, and graphic designers) from the College View congregation would be solicited for help in sponsoring booths that relate to their training, and the community would provide additional information on topics that the church lacked resources in. The product would be that the Seventh-day Adventist Academy, Union College, state and community agencies, community businesses, and

College View Church would work collaboratively to provide health information. This is the first step in achieving behavioral change and improved health status.

Other programs outlined in the COME ALIVE work plan and time line will be offered as subsequent events and activities throughout the year.

Hurdle #9 – Evaluation

Evaluation of faith programs is performed for reasons of program justification, improvement, effectiveness, or continuation, although, faith-based health programs are not in the business of meeting quotas like state and federal funding programs. At its most basic level, an evaluation portrays the program in terms of attendance and participation rates. Evaluation of program effectiveness can include much greater intricacy; program outcomes such as screening results, changes in risk factors, or remarkable case histories may be tracked (Schaeffer, et al, 1994).

Due to the multifaceted and unique nature of health ministry programs and the need to quantify the effect of programming for the purpose of future funding opportunities, a new method of health ministry evaluation has been developed. "Outcomes Engineering" is a term used to describe a systematic, qualitative process by which success stories of individuals are tracked for progress during his/her path toward positive change as it relates to health. Although at an infancy stage, Outcomes Engineering is predicted to be the future gold standard for evaluating faith-based health programs.

If one is not able to use this new method, borrowed best practices for evaluation from Health Education Programming would include a combination of process, impact, and outcome evaluations for each program offered by a health ministry group. *Process evaluation* provides documentation during program implementation to make adjustments for improvement in the program, for example, getting reactions from participants about the times programs are offered or about speakers in a workshop. *Impact evaluation* assesses the overall effectiveness of a program in producing favorable knowledge, attitudes, behaviors, health status, and/or skills in the target population; indicates immediate effects, such as a change in behavior or an increase in knowledge. For example, how many people can perform CPR? Finally, *outcome evaluation* determines whether the program met the stated long-term goals and objectives, such as a reduction in morbidity or mortality rates of the target population or an improvement in the quality of life (McKenzie & Jurs, 1993).

A series of questions may stimulate thought prior to and while creating evaluation methods.

(1) What activities, methods, strategies, or materials are most effective for individual groups (e.g., seniors, children, young adults, mothers, etc.) being targeted?

(2) How do diverse groups of congregation members rate health ministry volunteers and the content of classes or services offered?

(3) Has the program been implemented as planned?

(4) Can changes in knowledge, attitudes, and health practices be measured?

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(5) How will quality of life be measured?

(6) In what ways can the link between health status and the faith component of health be evaluated?

(7) What types of evaluative information and statistics will be needed to apply for potential grant funding?

The pastoral staff from any given congregation may also be curious to know the ways in which a health ministry program impacts church growth and spiritual development among individual members of the congregation. For these two particular areas, discussion with church boards and pastors may be helpful when creating evaluation tools that gather this information. Regardless of the type of evaluation chosen, different stakeholders will have different sets of questions that they would like answered. The important thing to remember when communicating evaluation results to appropriate key stakeholders and members of the congregation is that it is imperative to maintain mutual trust by keeping the communication lines open.

The COME ALIVE Health Ministry intends to use a variety of evaluation methods, depending on the type of program being implemented. In addition to improving programs and communicating with members of the congregation and pastoral staff, it is the team's desire that additional external grant funding be sought to assist with specific health ministry endeavors as the ministry grows and expands its programs and team members. The team understands that in order to submit a competitive grant proposal, evaluation data and feedback will be necessary. Evaluation results must not be filed away, but should be used in the provision of future health promotion programs.

Summary

This case study followed the basic principles of health education planning, implementation, and evaluation. In many instances, specific steps were adjusted slightly to reflect the uniqueness of faith-based organizations and its culture, which influences decision-making. The Seventh-day Adventist denomination values health, particularly through encouraging a vegetarian diet, Bible study, regular exercise, smoking and alcohol cessation, and abstinence-based sex education for youth. Each congregation will have values and health priorities that influence and individualize their program development.

The COME ALIVE Health Ministry chose to focus a majority of initial efforts on prevention-based programs in an effort to introduce the ministry and gain congregational and pastoral support. Plans are currently being laid for a second wave of programs that will attempt to provide more one-on-one interaction with members (e.g., home visits) as the ministry grows and becomes more familiar to members.

Health ministries like COME ALIVE are effective because they provide first-line personal care, health promotion programs, and resource referral services for community members who may at times slip through the cracks within a typical medical paradigm. Programs are interwoven with a whole person philosophy, including the mental, physical, intellectual, emotional, and spiritual dimensions of health.

Collaboration between faith-based health programs and traditional health care is becoming increasingly useful and important. The link between spirituality and health outcomes is now supported through research, and these programs greatly influence access to diverse population groups.

existing programs and the development of new programs is likely to grow as grant monies become more available through hospitals and community agencies.

Many larger communities now offer training on how to become a health minister or parish nurse. Interested parties should contact their local hospitals and other congregations in the area for information on nearby training opportunities and resources on how to start a parish nursing or health ministry program.

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Appendix

CVC

Parish Nursing Survey

CVC has established a committee of health professionals to coordinate a Parish Nursing Program. The goal of this program is to improve the health of body, mind and spirit among congregation members. As a part of the church family, these parish nursing health professionals will be providing a caring outreach of health education instruction, listening to members' needs, coordinating referrals to community resources, and facilitating the integration of faith and healthful living.

To help us plan for the CVC Parish Nursing ministry, we would appreciate your assistance in answering the following questions. All information is anonymous, confidential and will only be used for planning parish programs. ***Thank you for your assistance!***

Directions: The following are related issues and concerns. Please indicate *how likely or unlikely you would be to attend classes/workshops on these issues/concerns* by circling the number that best fits your response to each of the items, with 1 representing "Highly Unlikely" and 5 representing "Highly Likely."

(1) Highly unlikely, (2) Not very likely, (3) Neutral, (4) Very likely, (5) Highly likely

(A) Disease Prevention Programs					
1. Exercise	1	2	3	4	5
2. Stress Management	1	2	3	4	5
3. Nutrition	1	2	3	4	5
4. Stop Smoking	1	2	3	4	5
5. Personal Safety	1	2	3	4	5
6. CPR	1	2	3	4	5
7. Blood Pressure Screening	1	2	3	4	5
8. Weight Management	1	2	3	4	5
9. Environmental Safety	1	2	3	4	5
10. First Aid	1	2	3	4	5
(B) Physical Health Programs					
11. Eating Disorders	1	2	3	4	5
12. Heart Disease	1	2	3	4	5
13. Lung Disease	1	2	3	4	5
14. Diabetes	1	2	3	4	5
15. Arthritis	1	2	3	4	5
16. Birth Defects	1	2	3	4	5
17. Cancer- if yes, what kind_____	1	2	3	4	5
18. Osteoporosis	1	2	3	4	5
19. Back Pain	1	2	3	4	5
20. Alzheimer's Disease	1	2	3	4	5
(C) Emotional Health Programs					
21. Depression	1	2	3	4	5
22. Drug/Alcohol Misuse	1	2	3	4	5
23. Anger Management	1	2	3	4	5
24. Shame/Guilt Issues	1	2	3	4	5
25. Divorce	1	2	3	4	5
26. Death & Dying	1	2	3	4	5
27. Self-Esteem	1	2	3	4	5
28. Other_____	1	2	3	4	5
(D) Family Health Programs					
29. Pregnancy	1	2	3	4	5
30. Fertility	1	2	3	4	5
31. Parenting/Discipline	1	2	3	4	5
32. Quality of Life Issues	1	2	3	4	5
33. Medication Management	1	2	3	4	5
34. Mid-Life Crisis/Menopause	1	2	3	4	5
35. Crisis Intervention (death, divorce, etc.)	1	2	3	4	5
36. Family Finances	1	2	3	4	5
37. Elder Issues (caring for aging parents, etc.)	1	2	3	4	5
38. Adolescent Health Issues	1	2	3	4	5

(1) Highly unlikely, (2) Not very likely, (3) Neutral, (4) Very likely, (5) Highly likely

(E) Spiritual Health Programs

39. Home Visits	1	2	3	4	5
40. Prayer Classes	1	2	3	4	5
41. Other_____	1	2	3	4	5

Directions: To help focus future program development for specific groups of participants, *please tell us a little bit about yourself.*

42. What day/s of the week and time would be better for you to attend a class or group?

a.___Monday AM e.___Wednesday AM i.___Friday AM
b.___Monday PM f.___Wednesday PM j.___Saturday PM

c.___Tuesday AM g.___Thursday AM k.___Sunday AM
d.___Tuesday PM h.___Thursday PM l.___Sunday PM

43. Do you have health insurance? _____No _____Yes

44. Would you be interested in receiving a home visit from a parish nurse or other health professional from the CVC Parish Nursing program? _____No _____Yes

45. What is your age? _____

46. Male _____ Female _____

47. What is your marital status? _____Single _____Married _____Divorced _____Widowed

48. What is your employment status? _____Not employed _____Full-time _____Part-time _____Retired

49. What is the highest level of education you have completed as of June, 1999? (Please circle one)
a. Some high school
b. High School Diploma
c. Associate's Degree
d. Bachelor's Degree
e. Master's Degree
f. Doctorate Degree

50. *Health Status*: If you have or had any of the following conditions, please place a "C" by any current conditions and a "P" by any past conditions.

a. ___Heart Disease h. ___Lung Disease
b. ___High Blood Pressure i. ___Cancer
c. ___Arthritis j. ___Osteoporosis
d. ___Diabetes k. ___Back Problems
e. ___Depression l. ___Obesity
f. ___Eating Disorders m ___Thyroid
g. ___High Cholesterol n. ___Mental Illness

51. What is your major health concern(s)? (This includes emotional, physical or spiritual.)

_____

_____

At this time, we would like to personally thank you for taking time and expending the effort to complete this survey. Your opinions and ideas are greatly appreciated and will help the CVC Parish Nursing Program develop programs that you're interested in and feel are necessary. If you have any questions regarding this instrument or would like to get involved with the program, please contact Cheryl Lockett at 486-1617 or Wanda Hilton at 423-9323. Again, *thank you!*